NORTHWEST JOURNAL OF OPTOMETRY

VOL. 2. No. 7 JULY, 1925

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NORTHWEST JOURNAL OF OPTOMETRY
VOL. 2 JULY, 1925 No. 7

NOTES ON ANISOMEROPIA

Ernest Fielding, Opt. D., F.A.A.O.
Kansas City, Mo.

A variation of one dioptre in ocular refraction can be caused by the small difference of 1-6 of a millimeter in the radius of the cornea, or by 1-3 of a millimeter in axial length of the eye. It is not surprising, then, that the refraction of an eye will frequently differ from its mate. More surprising is the fact that there are many persons in whose eyes we cannot, by our science and skill, discover a correctable difference of error. This condition is called isometropia. Where we find an appreciable differenee in refraction we have the condition known as anisometropia.

Isometropia is considered an ideal condition as is emmetropia, and as a slight deviation from the latter does not constitute a real anomaly, so a slight anisometropia is not regarded as difficult of correction. Anisometropia can only be considered a defect in itself when it is sufficient to cause some disturbance, either visual or nervous. The refractive difference which may be regarded as capable of causing trouble will vary according to the refraction. For instance, having one eye emmetropic and the other myopic two dioptres we could not fail to find great discomfort in binocular vision. But if one eye was myopic seven dioptres and the other five dioptres, while the same amount of anisometropia existed as in the previous case, yet there would not be the same severity of symptoms.

The term anisometropia does not signify the state of refraction of either eye. One eye may be normal and the other hyperopic; one eye may be hyperopic and the other myopic; both eyes may be hyperopic or myopic, differing only in the amount of error. Astigmatic eyes can also be anisometropic in the same manner. Anisometropia is either acquired or congenital, being more frequently the latter due to defective or retarded developmnt. The acquired types come generally from injuries or disease. Removal of the lens of one eye for cataract gives rise to an anisometropic condition that is exceedingly hard to correct and at the same time give binocular vision.

Vision in anisometropia may be accomplished in three ways: there may be binocular vision; vision may be monocular, either eye being used alternately; or vision may be monocular, one eye being used to the exclusion of the other.

When the vision is binocular there is, of course, greater difficulty and the patient suffers more discomfort. If the condition is endured long enough uncorrected, it will probably turn into the second or the third type, depending on the kind and amount of refractive error. If one eye is nearly normal and the other three or four dioptres myopic, the patient will learn to use the better eye for distance and the myopic eye for near vision. Anisometropia of the third type generally exhibits strabismus.

Since any kind of refractive error can give rise to asthenopia, it is difficult to make a differential diagnosis. The asthenopia may come from the strain to correct the refractive error or it may be due to the inequality of refraction. As mentioned in the previous paragraph, if binocular vision exists there will be anisometropic asthenopia due to nerve exhaustion in the effort to maintain binocular vision. There is an indistinctness of images in the poorer eye and ofttimes the images are of unequal size. The latter condition will be taken up later in this paper.

When anisometropia has existed since birth, the eyes may never have learned binocular vision. In all probability there is strabismus which, perhaps, is not evident on casual inspection. But even then, asthenopia may arise at any time from a special tax on the eyes or when the reserve supply is drained from any cause.

It is the writer's practice to attempt rather full correction in all cases of anisometropia. Unfortunately a number of patients cannot tolerate the lenses and they must be changed. Re-

cently, however, we have noticed an increase in the number of anisometropes who could learn to wear their full corrections.

Just previous to writing this article we reviewed several classic authors on the subject. One in particular, after explaining the whys and wherefores of anisometropia, advised against even attempting a correction of the poorer eye. His method was to correct the better eye and give the same lens to the other! Another authority stated that there should never be a difference of over 1.50 dioptres between correcting lenses! As stated in a preceding paragraph, the writer has noticed an increase in the number of anisometropes who could wear rather full corrections for their refractive error. We believe that this is due to our method of procedure, which follows. The full findings are seldom put on at the first sitting. The patient is instructed as to the nature of his case and advised just what we expect to accomplish. Often two pairs of lenses are given; one for distance and one for near work, the latter being full dynamic findings if possible. We believe it is easier to give the correction for anisometropia in a near prescription than in a distance one, for the reason that vision is closer to the optical center of the lenses and the prismatic action is less than when viewing objects through the periphery of the lenses.

The ophthalmometer is a great help in anisometropia and we expect to be able to supply more definite data on its use in such cases later. We are keeping a careful record, but cannot at this time give proof. However, our philosophy can be explained in the hope that others may work out the problem. The image in both axial hypermetropia and axial myopia is the same size as in emmetropia. If the correcting lens is placed at the anterior focal point of the eye (said to be in front of the cornea about 14 millimeters) there will be no alteration in the size of the image. The image will simply be moved forward or backward as the case may be. It follows, then, that if the error of refraction is axial and the lens is placed properly, there will be clear vision in both eyes and the images will be of the same size. The patient should be able to wear such a correction for distance at least. When accommodation is in force there is an alteration in image size, but I shall not discuss the fact in this paper. It would seem that the opthalmometer could be used much as a lens measure to determine the refractive power of the eye. With this information at hand the examiner could judge whether or not the refractive error was axial or refractive. If the major meridian of one eye measured 46.00 dioptres and its mate 41.00 dioptres it would seem that the error was refractive and full correction would be of doubtful success. But if both eyes measured practically the same in power, the error would be judged axial and we would expect good results with close correction.

We are very careful about the lenses in such cases and have several original ideas on the subject. In the first place, we grind the lenses so that the outer surface of each lense has the same curve. If there is a cylindrical element we prefer to have it on the rear surface.

The greatest difficulty encountered by the wearer of an anisometropic correction is the prismatic action of the lenses when the line of vision is away from the optical center. It is this fact that prohibits bifocals in anisometropia. The bifocals themselves are not at fault, but near vision is of a necessity from five to eight millimeters below the center. If the lenses vary considerably in power there would be a great disturbance in vision. Suppose our patient is wearing minus 3.00 dioptre in the right eye and plus 3.00 dioptre in the left; at a point five millimeters below the center of the lens there would be 1.50 dioptre of prism base down in the right lens and the same amount base up in the left. This is quite enough to produce diplopia and of course our patient could hardly tolerate bifocal lenses. Because of this prismatic action we must take special care in the centering of our anisometropic prescriptions. In the lenses used for distance we place the optical center on a line with the visual axis when the eyes are directed toward the ground twnty feet away. For reading corrections the lenses are decentered downward depending on the habits of the patient. It can easily be seen why

we must be so careful in this if we but remember that very slight excursions of the line of vision away from the optical center will bring very strong prismatic action. For this reason our patient is instructed not to attempt to use the edge of his lens to any great extent, but to turn his head bird fashion toward the object he wishes to view.

We try to avoid extremely large lenses. We also make up the prescriptions with low curves and in extreme cases use glass of a higher index in order to have the lenses as thin as possible.

Many of us enjoy prescribing deep meniscus lenses, but we only court trouble with our anisometropic cases when we use them. The writer uses many toric lenses in the ordinary run of cases, but never in high anisometropia.

Anisometropia permits of deep study and the successful handling of these cases will give you many hours of interesting and enjoyable work.

THE MARYLAND CLINIC

J. Fred Andreae, Opt.D.
Baltimore, Md.

A brief resume of the reasons underlying the establishment of the optometric clinic for poor children of the Maryland Association of Optometrists would probably be appropriate before describing the clinic and its work.

Each hospital in Baltimore has its so-called "free dispensary," where a poor person needing glasses may have their eyes examined. They are given a numbered slip which they must take to a designated prescription optician and the glasses are furnished at a minimum cost of $7.00. Might mention here that for this $7.00 an aluminum frame and flat lenses are generally furnished. The prescription optician makes a rebate of 50% or more to the hospital, making a profitable business out of a supposedly charitable enterprise. The hospital also receives a substantial sum each year from the state to care for its indigent cases.

Is this charity?

It is true that the deserving person can make application to the Welfare Association and after a lot of "red tape" would be furnished with glasses without cost, but in the case of the poor child the parents in all probability will not exert themselves to this extent and consequently the child struggles along as best it may.

Knowing these conditions to exist our association conceived the idea of establishing its own clinic with the intention of furnishing glasses to worthy poor children, without a penny of cost.

In January, 1923, a committee was appointed to locate and rent suitable quarters. Another committee was appointed to see the city officials and offer the clinic's service for the poor children. Our offer was accepted and the school nurses assigned to schools located in sections covered were instructed to bring children in need of glasses to the clinic.

Clinic is open three afternoons each week, Monday, Wednesday and Friday from 1 P. M. until all cases are disposed of. Work is in charge of a chief and three or four assistants. Right here it might be pertinent to state we have found it very difficult to get our members enthused over this wonderful work and have been able to get the active help of only eleven members from a total membership of eighty. As a matter of fact if the optometrists of the state of Maryland realized that the successful operation of this clinic (and it has been successful) means dollars in their pockets, respect from the other professions and increased publicity for our own profession, advancing optometry more rapidly than would be possible by any other means and at the same time the opportunity to take part in a 100% social service, we would have their unanimous support. When

we get that support, our advancement will be rapid and optometry will be so firmly entrenched in the public mind that our professional future will be assured.

The school nurse presents the patient, giving history and making recommendation in the case, stating whether patient is able to pay and how much. In event they are unable to pay anything, the word of nurse is accepted and glasses are furnished free of cost.

An amusing and at the same time sad incident happened a short time ago. A nurse brought in a little fellow about nine years old, stating the glasses were to be free as the boy's father was dead and it was a struggle for the mother to get along. At this point the boy spoke up and said he wanted to pay for the glasses and inquiry brought out the fact that the boy had received a five dollar note from his uncle to buy some much needed wearing apparel. The youngster said, "I can always get clothes but not eyes." The child's good judgment so impressed the examiner that he furnished him with a nice pair of glasses with his compliments.

Many incidents are very impressive and emphasize the dire need for this clinic. It is to be regretted we can cover only a very smal portion of Baltimore's poorer district.

The clinic occupies a room about 20x40, being divided into a reception room containing 15 chairs and one fitting table. Four refracting booths are in the rear and contain the following equipment; three Twentieth Century cabinets and mirrors, two luminous retinoscopes and opthalmoscopes, one Geneva opthalmoscope and one Universal opthalmometer.

One thing that is surprising is the fact that the clinic is nearly self-supporting. Our income is derived from 40 men who pay $1.00 per month (the rest of our membership will not pay even this dollar, which means about three cents daily for the most worthy charity we know anything about). The Baltimore Optical Company furnishes frames and glasses at the hundred price, edging and fitting included, and the balance is made on sale of glasses.

In free cases we furnish military aluminco frames and flat lenses. When patient is not satisfied with this, an inner rim frame and toric lenses are furnished for $5.00, regardless of prescription.

At the present time we are taking care of about 45 children weekly. These are all new cases. This is our limit because of lack of physical help. Could we get the necessary assistance we could be open every afternoon and also establish additional clinics.

The school nurses are enthusiastic about this clinic because there is so little "red tape" encountered and our work has measured up in every respect. We have not the slightest doubt but that when the city officials are advised of our work and figures are presented that any request within reason will be cheerfully granted.

Regarding our system of operation the writer will cheerfully explain in greater detail to any interested persons. It is our opinion that the successful operation of a clinic such as ours affords us the best publicity obtainable; it enables optometrists to accomplish something of worth for their fellow men and it constantly serves as a post-graduate course for the optometric practitioners engaged.

A POST GRADUATE CLINIC IN OKLAHOMA

W. S. Farmer, Opt.D.
Oklahoma City, Okla.

We returned from the American Optometric Association's convention at Kansas City, very enthusiastic over the clinic plan, and with a determination to give it a trial in our own state.

At the next meeting of our board of directors, the writer was elected chairman of department of education, and instructed to work out plans for a clinic in this state. Following these instructions we immediately corresponded with A. O. A. secretary, Kiekenapp, regarding his clinic plans; also Eimer of Michigan, and others. After deciding on Dr. A. M. Skeffington as our clinician, and securing the approval of the A. O. A. department of education, we went before the board of directors of our state association and secured their approval of our plans; which included the holding of a free public clinic, conducted by picked optometrists of the state, this as a side clinic to care for the overflow from the post-graduate clinic, held in adjoining room, by Dr. Skeffington.

We understand Oklahoma is the first state to use double clinic rooms. It was decided to hold a clinic in connection with the convention of state association on April 20-22. April 20th being devoted exclusively to business. Dr. Skeffington arrived early in the morning of the business session, and was kept busy lecturing before schools, civic clubs, etc., that day. The next two days were devoted exclusively to clinic work.

For a successful clinic, we found the following committees should be appointed, and instructed to do the things for which they were appointed, for if one committee fails to function it retards the progress of all.

1. Arrangements committee.
2. Publicity committee.
3. Registration committee.
4. Clinic room committee.

The arrangement committee should be the advanced committee as it is necessary for other committees to know what arrangements have been made.

Publicity Committee.—Our publicity committee secured several hundred inches of choice newspaper publicity by starting about two weeks prior with advanced stories in all papers, and keeping it up every few days with different parts of the story, featuring the fact that it was a free public clinic, and playing up the chief clinician. His lectures before civic clubs, schools, etc. There is no limit to this sort of publicity, as newspaper men are anxious for something new, and if they are permitted to do so will make pictures of the clinic at work, to accompany their writeups. It is always a good plan to have one or more reporters listed as patients and go through a complete examination; from their experience in the clinic room they can get the message to the public in an interesting way. This committee also has charge of the speaking engagements.

Registration Committee.—Our registration committee was just swamped with patients from all walks of life, begging and almost demanding examinations. Here great care and diplomacy must be exercised on the part of the committee as to promises, for we found that 6 to 8 patients per day was all that Dr. Skeffington could care for, in the post-graduate clinic. In the public clinic, patients were handled faster as lectures and explanations were dispensed with.

Here the writer agrees with Dr. Cochran, and others who think the patient should be given a prescription; this we did together with a list of the equipped association members in the city, and advised them to have their prescription rechecked, by a local optometrist. In many cases, in fact in most cases, the ones that could not be examined were given a list of the local optometrists that were fully equipped. They of course regretted that they could not be examined by the clinic, but were glad to get a list of the leading optometrists near them. People came for an examination from all parts of the state. It is embarrassing to an-

swer direct personal questions before a packed audience, therefore all history and available data of this nature should be taken in private, by one of this committee.

When the record card with the case history is properly filled out, it is presented to the examiner for his information, by one of the clinic room committee, together with the patient for examination. One or more members of the clinic room committee should be present in the clinic rooms at all time to assist with the equipment, etc.

Regarding equipment we are deeply indebted to The American Optical Co. of Oklahoma City, for the loyalty of their representatives, and the splendid co-operation in equipping an ideal optometric examining room, with their new complete professional unit; also to the Riggs Optical Co. of Oklahoma City, for the use of their Geno-thalmic unit.

Following the examination the clinic room committee working with the registration committee sees that the patient gets a copy of his prescription together with a list of the qualified optometrists of his city. The original prescription is filed with the registration committee.

In the writer's opinion it is absolutely necessary for best results to have the chief clinician a man from out of the state, as local optometrists are not inclined to give the desired attention to one of their members. We heartily endorse the Kiekenapp national plan of clinics, for in that way the local, state and national associations profit, and it puts optometry before the public in its proper professional way.

All kinds of eye troubles came for examination, six totally blind, many pathological, and refractive cases of every description. Some 65 were examined, and hundreds were turned away without examinations. And all of this from a few mere announcements from newspapers, that the chief clinician of the American Optometric Association was to hold the clinic. Dr. Skeffington in his characteristic manner worked hard, delivering lectures before schools, clubs, etc., but in the clinic examining room, he was at his best. A very rapid speaker and worker, he is easy to listen to; his methods and technic, together with his outline of procedure was thoroughly explained, and easily understood. Truly he brought us many new and practical ideas.

In conclusion, we here in Oklahoma now believe that the clinic idea is the one great thing above all others that will put optometry in its proper professional sphere, in a respectable and professional way. Optometry is becoming one of the greatest professions. Even now a great professional wave seems to be sweeping the entire Optometric world; all over our country, optometrists are moving upstairs to professional buildings and better quarters; throwing out their old worn out equipment and equipping with the new professional scientific units. They are learning the lesson of co-operation with one another and with civic agencies. They are now doing a greater scientific work than was dreamed of a few years ago. Truly the outlook is bright.

SOCIETY PROCEEDINGS

MINNEAPOLIS ASSOCIATION OF OPTOMETRISTS

May 20th, 1925

Dr. L. L. DeMars Presiding

Focal Infections and Radiography

Dr. J. A. Heidbrink, speaking of the relation between Dental Infections and Ocular Defects, stressed the point of a careful analysis of the oral cavity in every ocular case not responding rapidly to customary treatment. During his talk he used a Balopticon and threw upon the screen various radiograms of the oral cavity. His talk consisted chiefly of discussion of various cases in which streptococcus infections had resulted in various forms of pathology.

Imbedded Root Tip

Case One. A patient in which all teeth had been previously extracted. Dr. Heidbrink said this was one of the stumbling blocks of the dental and medical professions, inasmuch as it is so easy in a case of this kind to as-

sume that, as there are no teeth present, there can be no focal infections present in the oral cavity. He showed various radiograms illustrating this type of case in which small root-ends of teeth were left in the bone process as the teeth were extracted. These small particles of root-end later became the seats of streptococcus infections. He also at this time strongly advised against the procedure of merely raying portions of the mouth. All teeth, he claimed, should be radiographed at regular intervals and the readings of the plates should be made by dentists skilled in this type of work.

A Case of Iritis

Case Two. This case of iritis was relieved by the removal of an infected area around what appeared to be, in the radiograph, a normal bone structure. In this case the infected area was not walled off, but had honeycombed the bone process in such a manner that it did not show in the plate. This patient, Dr. Heidbrink explained, had been examined by several dentists who had pronounced the oral cavity normal. The honeycombed area was curretted away and the case rapidly recovered. Dr. Heidbrink showed the portion of bone process which had been removed. This he did by filling up the cavity in the bone structure with gutta-percha and then making another plate of the jaw. The gutta-percha showing white in the plate.

At this time he called attention to Dr. Price, a nationally known dental surgeon who was devoting his life to the study of streptococcus infections. He explained how Dr. Price had made cultures at a distance of at least half an inch from the root end of a devitalized tooth and from these cultures had grown streptococcus bacilli. It was by this mode of infiltration that the infected area around an infected devitalized tooth came to pass. At times the infection will rot away the bone process and keep spreading—at other times the system would wall off the infected area, thus permitting the leucocytes to fight the infection.

A Walled-in Infected Area

Case Three. Dr. Heidbrink showed the radiographs of a lower bicuspid at the end of which could be clearly seen the walled-in socket localizing the infection. Upon the removal of this tooth, said Dr. Heidbrink, he was unable to grow the streptococcus bacilli from this socket, so well had the leucocytes performed their work of combating the infection.

A Maxillary Sinusitis

Case Four. He next showed a case of maxillary sinusitis. In this radiograph he showed an upper infected first molar, the tip of which protruded up through the floor of the antrum. Upon the removal of this tooth, they found the antrum full of pus. After draining for two weeks the case was discharged as cured, the sinus trouble having disappeared.

Asthma From an Infected Root Tip

Case Five. In this case the patient had suffered from asthma for years, trying one treatment after another with no results. Upon making a radiograph, Dr. Heidbrink found a concealed root tip which proved to be a source of infection. Three months after its removal, the case reported a complete recovery from asthma; all the distressing symptoms having disappeared and the patient further reporting a gain in weight.

Neuralgia

Case Six. The patient claimed that for seven years she had never gone more than forty-eight hours without pain. Again a portion of root tip was found to be the seat of the trouble, which cleared up in a short time after its removal. He then pointed out the difficulty of removing these sometimes tiny portions of teeth, which, due to their curvature, frequently break off as the extraction is made. He then briefly outlined a few of the numerous forms of technic used in getting at these small particles.

Neuritis

Case Seven. Again a case of infected dental area caused by root tip. Within four days after curretting, the case had relief, the patient further reporting that the symptoms had never returned.

Irido-Cyclitis

Case Eight. This case was one of thirty years' standing. The V.A. was O.D. 20%, O.S. 10%. The patient had four devitalized teeth, each being a

source of infection. Thirty days after their removal the patient's visual acuity was: O.D. 90%, O.S. 30%, the cyclitis having entirely cleared up.

Asthma

Case Nine. In this case a radiograph was made which disclosed a small root tip touching the floor of the antrum. These are particularly difficult cases to handle, inasmuch as one is likely to puncture the floor of the antrum, forcing the root tip up into the cavity, thus making it very difficult to recover. Dr. Heidbrink's technic is as follows: Starting with a vertical incision on the outer side of the gum, laying back the membranes and periosteum and then making a small opening in the bone wall through which the root tip was removed, thus clearing this patient's asthma within two weeks.

Iritis

Case Ten. In this case the trouble was found to be a cyst located between the roots of two upper molars. Upon the removal of this cyst (easily seen in the radiograph), the infection at once subsided.

Cyst at Base of Antrum

Case Eleven. A large cyst was located at the base of the antrum at the left. This cyst was oval in shape, three-quarters inch in length and perfectly walled off. The area quickly healed after its removal.

Cluster of Imbedded Minute Teeth

Case Twelve. Here the radiograph disclosed a cluster of four minute teeth located at the base of and between two molars. In this case, the tooth germ had formed imperfectly, the four tiny teeth being the result. This cluster, surrounded by bone process, became infected and was the cause of a severe strep infection. Upon its removal along with the infected bone the patient showed rapid improvement.

Neuritis

Case Thirteen. Girl employed as traveling saleswoman, who was forced to give up her position because of severe headaches and loss of weight. Came to Dr. Heidbrink because of a soreness in the palate. The radiograph discovered a cyst which started at the left bicuspid and extended to the right second molar. The entire covering of the palate in this case was laid back and the palate bone and cyst removed. The area was then packed and drained. After forty-eight hours new bone started to form and at the end of thirty days not only had the palate reformed normally but the neuritis was entirely relieved and the patient had regained weight.

Dr. Heidbrink then called attention to Dr. Price's experimental work, telling of his checking one thousand cases where the strep areas were not walled off. These cases, Dr. Price found, had a low ionic index—in other words, their resistance was low. On the other hand, in cases where the strep area is walled off, the reverse is true.

Discussion

DR. R. L. MUNNS. Do I understand you to say that when the source of infection is walled off there is no harmful effect?

DR. HEIDBRINK. No, in very few cases would it be walled off in such a manner as to exclude any possibility of the infection reaching other portions of the mouth or system; however, this is nature's intent. In many cases, nature throws a protective wall around the infected area to keep it from spreading.

DR. C. C. KOCH. I was quite interested to hear of your oral X-Ray work on patients who have previously had all of their teeth removed. Would you endorse the immediate removal of all such bone tips found irrespective of the appearance of the surrounding area?

DR. HEIDBRINK. By all means. These little tips are nearly always a source of trouble and should be removed. The same is true of devitalized teeth.

DR. G. L. DU PLESSIS. What is the apparant variance of effect of infection due to? For instance, one patient having a dental infection suffers from iritis, another from cyclitis, etc. Could it be possible that the infections seek out the weak portions of the systems and attack there?

DR. HEIDBRINK. Possibly; at any rate your question is difficult to answer. Various authorities have their theories, but as yet nothing can be proven. However, this much has been done: A patient suffering from iritis,

as you mentioned, due to a strep infection in the oral cavity, has the infection removed. A culture is made and the strep bacilli are then propagated and given to some small animal. This animal will have iritis. The same is true in other types—the strep bacillus from a person suffering with one type of pathology will always produce a similar pathological reaction, never another disease.

DR. J. I. KURTZ. I recently had a case, a girl ten years of age, in which there was a paralysis of the external rectus muscle. Suspecting a focal infection to be the cause, I had the case examined. The tonsils were infected and were subsequently removed. I thought we should see some improvement within a month, but it was more than six months before any was noticed. Is it not true that in cases of infection similar to this, the improvement is generally more rapid?

DR. HEIDBRINK. Yes, as a general rule pathology caused by strep infection shows signs of improvement in from four to thirty days.

DR. E. O. FJELSTAD. I have a patient whose cardiac muscle is affected. At least such is the diagnosis of her family physician. Her teeth are in poor shape and it seems to me that this heart trouble might be caused by a dental infection of some sort. Could this be true?

DR. HEIDBRINK. It is quite possible. We never know where an affected area will spread or what portion of the body will be affected by a strep infection.

G. L. DU PLESSIS, Opt. D.,
Clerk.

BOOK NOTICES

New Books for review should be sent to Dr. E. O. Fjelstad, Red Wing, Minnesota. Only Books of such nature as to be of interest to optometrists will be used in this department. Optometric and Ophthalmic publications that have been issued in the past and which are still procurable through their publishers will also be reviewed, from time to time, as space permits.

OPHTHALMOMETRY. By E. Le Roy Ryer, Opt. D., D.O.S., F.A.A.O. Pp. 220. Illus. 59. Price $3.50. New York: The Optical Publishing Co., 11 John Street. 1925.

We have just received a copy of Ryer's new book and with an inherent curiosity perused its contents in one sitting. Our curiosity was because of the subject, which, we all know, has been lightly considered in general texts on the eye, and we were desirous of knowing how much of the subject we were not familiar with. Our interest was so great and the author had arranged the subject in so pleasant and readable a manner that we could not leave it.

Ryer here treats ophthalmometry as a clinical subject and has left out the theoretic and the historic phase, which, in our opinion, makes the book all the more valuable. Before the first hour of reading was over we had developed a greater love for our ophthalmometer and realized we had neglected many salient facts concerning its usefulness.

Ryer has divided the book into five parts, as follows: Part One, General Principles in Practical Ophthalmometry Common to All Forms of Ophthalmometer. Part Two, The Universal Ophthalmometer, covering the method of using this instrument and its comparison with others. Part Three, The C-I Ophthalmometer, explaining the working features of the Hardy instrument. Part Four, The Sutcliffe Keratometer, covering the features of an instrument little known in this country. Part Five, Illustrative Cases, a digest of typical cases as explanatory to why an ophthalmometer should be used.

Ryer should be commended on the masterly fashion of developing a subject so lightly treated heretofore and the Optical Publishing Company should be congratulated on their willingness to carry the work to an end. We urge all thinking and progressive optometrists to obtain this book, not as just another book for their library, but as one to be read and studied.

E. O. F.

NOTES, CASES AND INSTRUMENTS

THE ORIGIN OF PUNKTALS

J. H. W. Kerston
New York City

May we not ask you to give space and publicity to the following, prompted by an article "The Problem of the Spectacle Lens and Its Solution in the Punktal" by E. O. Fjelstad, featured in the May issue of the Northwest Journal of Optometry, containing a number of inaccuracies and discrepancies, which in the interest of historical truth should not be left unchallanged.

As lack of space and time prevents us from going into details, we will confine our corrections to a few outstanding misstatements, directly concerning the history of Carl Zeiss, Jena.

Referring to the last paragraph in the second column of page 130, we read: "Early in the twentieth century the Bausch & Lomb Company suggested to the Zeiss Works that a new form of lens could be designed." We beg to point out that the idea of "Punktal" lenses never originated with the firm of Bausch & Lomb, nor was it ever suggested by them. As a matter of historical fact, the principles underlying "Punktal" lenses were first suggested by Professor Alvar Gulstrand, the celebrated Swedish ophthalmologist, but the idea of and the actual mathematical computations for "Punktal" lenses were created in 1908 by Professor Moritz von Rohr, scientific collaborator of the Carl Zeiss Works, at Jena.

Further on we read with amazement: "The lenses were too thick for practical purposes and the jumps between the powers were too great." This does not, however, correspond with the actual facts, at least as far as Carl Zeiss "Punktals" are concerned. As a matter of record the Zeiss Optical Works had manufactured "Punktal" glasses, without encountering any of the above cited difficulties, long before Bausch & Lomb ever undertook their manufacture under Carl Zeiss patent license in 1913.

Carl Zeiss "Punktal" lenses were patented in Germany and most civilized countries, including the U. S. A., during the years from 1908 to 1910 and have been manufactured at the Jena factory in large quantities ever since.

ABSTRACT DEPARTMENT

Optometric and ophthalmic journal articles and reprints to be abstracted should be sent to the editor. Only papers on subjects of interest to optometrists will be reviewed in this department.

Blackmar, F. B. A Scotoma Plate Attachment for Perimeters (Ill.). American Journal of Ophthalmology, Series 3, Vol. 8, pp. 377-380. 1925.

Blackmar describes a shield-like scotoma plate arranged so as to be hooked over the center of the perimeter arc. The plate is a disc of copper or aluminum hammered so that its radius of curvature is the same as that of the perimeter. For a fixation object a small retinoscopic mirror is cemented into the center. Two metal hooks are fixed to the posterior surface to afford a means of attachment to the arc of the perimeter. The disc is painted nonglossy neutral grey, and concentric circles, corresponding to the ten degree marks of the perimeter are drawn lightly on the concavity of the disc. After the normal right and left blind spots have been drawn in their appropriate positions the plate is finished.

The scotoma plate is used just as a campimeter. The test object is glued to a wire object carrier painted the same color as the plate. When examining a patient dots may be made on the plate with chalk to mark the limits of scotomata and fields. T. O. B.

Dean, R. S. Visual Surveys in Schools and Industries. The North Carolina Optometrist, Vol. 1, No. 7, p. 5. 1925.

In making a survey of an industrial organization, says Dean, our first consideration is to determine the amount

of illumination, both natural and artificial, and to decide if they co-ordinate without producing glares or shadows.

Next we make time studies, to determine the amount of work accomplished under present conditions. Then, we make the case history. Under this heading comes Character Analysis, the effects of malnutrition and the results of dissipation. At this time we discover the attitude of the employee toward the organization and his future ambitions, if any. We next discover any pathological conditions; and who are color blind; any latent errors, and make a visual acuity test. We then consider each individual under his present conditions of work, and with his case history, decide on the correction needed.

T. O. B.

Jellings, C. N. T. Ophthalmoscopy and Retinoscopy. The Optician (British), Vol. LXIX, No. 1779, pp. 200-202. 1925.

Jellings describes a few of the retinal changes most frequently seen in viewing the fundus with the ophthalmoscope and cautions refractionists that these changes are in nearly every case associated with ocular pathology.

1. Whitish areas of different shapes and sizes which are caused by exudation of albuminous fluid, by the formation of fibrous tissue, or by gaps in the choroid showing sclera exposed to view.

2. Hemorrhages, which are always red and assume different shapes and sizes according to the position they occupy in the various tissues.

3. Pigmentary deposits which may be excessive or may be only fine and granular and arranged in different formations. It is important to remember that any pigmentary changes are always associated with diseases of the choroid and choroidal circulation, owing to the fact that the choroid is a pigmented structure.

4. Alteration in the appearance of the optic nerve and retinal vessels.

Jellings also goes into some detail regarding the principles of static skiametry.

T. O. B.

Schoenberg, M. J. The Knapp Adrenalin Mydriasis Reaction in Direct Descendants of Patients with Primary Glaucoma. Archives of Ophthalmology, Vol. LIV, No. 3, pp. 282-287. 1925.

Schoenberg briefly reviews some of the previous literature on glaucoma, quoting Knapp's adrenalin mydrasis reaction diagnostic test for patients suspected of having glaucoma. He further quotes various writers on the subject of hereditary glaucoma and agrees with them that there seems to be an hereditary tendency on the part of certain families towards glaucoma. This being true, he reasons that it would be of great value to know, if possible, the incidence of this hereditary predisposition in the direct descendants of such patients, providing these descendants would show a susceptibility to adrenalin.

Thirty-five individuals, sons and daughters of thirteen patients with primary glaucoma, were submitted to the Knapp test, which is given as follows: "After taking the tension with the Schiotz Tonometer and measuring the diameter of the pupil, one drop of adrenalin solution, 1/1000, is instilled every few minutes for five times. After a half hour the measurements of the pupil and the ocular tension are again taken. Any dilation of the pupil indicates a predisposition towards glaucoma.

Schoenberg found among this group that about 50 per cent of the direct descendants of patients with glaucoma gave a positive Knapp adrenalin reaction, indicating that nearly half of the descendants of patients afflicted with primary glaucuma have a tendency towards this same disease.

C. C. K.

Smith, D. P. Centripetal Fan Scotoma in Glaucoma. British Journal of Ophthalmology, Vol. IX, No. 5, pp. 233-240. 1925.

Smith charted the visual fields of 44 chronic glaucoma cases, and 25 of these charts are illustrated with his paper. These charts are selected as having one noticeable feature in common, namely, a scotoma tapering from the periphery of the field towards the fixation point, and not connected with, nor leading towards, the blind spot.

T. O. B.

THE NORTHWEST JOURNAL OF OPTOMETRY

VOL. 2. No. 7 **JULY, 1925**

PUBLISHED MONTHLY BY THE IOWA, MINNESOTA, NEBRASKA, NORTH DAKOTA AND OKLAHOMA OPTOMETRIC ASSOCIATIONS

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Annual Subscription Two Dollars in Advance. Single Copies 20c

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JACK I. KURTZ, Room 209, Yeates Building, Minneapolis, Minnesota.

The Journal has no objection to the reprinting by other magazines of any of its articles, providing such reprints are properly credited to the Northwest Journal of Optometry

THE EVOLUTION OF THE OPTOMETRIST

For years it has been considered essential for an optometrist to have at his command the necessary knowledge and equipment to enable him to refract cases as they came to him and to diagnose various types of visual defects. His work has been, in most cases at least, entirely along this line. Now, however, newer fields are opening to the optometrist. No longer is the scientific, university-trained optometrist content to sit back and merely refract and prescribe for his cases. Indeed he has found out that many cases required much more than a mere ocular prescription to accomplish the desired results. He found that a small number of his patients were dissatisfied and were going to other optometrists—where, unfortunately, nothing more was accomplished than had been in the first place. What was the reason for these failures? The more scientific his training, the more thorough he became in seeking out the cause of his defeats and shortly he found, first, that his work was too hurried—a single call was in many cases insufficient for a complete refraction, and second, that in certain cases a period of observation must elapse before anything of a definite nature could be prescribed.. This was a splendid start for the things that were to come. In observing these cases he was quick to see that certain forms of oculo-prism treatment must be prescribed in cases of convergence weakness and exophoria before an ocular prescription could become effective. He was quick to see that by certain vision-stimulating devices he could, in many cases of amblyopia ex anopsia, materially improve vision and that the corrective treatment through lenses, exercises and occlusion for cases of convergent and divergent squint were far better than merely prescribing for the manifest defect or hoping that the patient would "outgrow" the defect. Again he found in anisometropic cases, that by the careful prescribing of partial corrections at first and by the continued careful building up of the correction the visual acuity could be slowly brought to normal, correcting the entire defect in each eye with comfort and success. And in the simpler cases, too, he found the use of repression lenses of great value and while of course their use materially slowed up the work it nevertheless made the work more accurate and patients were quick to take advantage of his thoroughness and his attention to detail.

The optometrist of today is emerging from his role of a prescriber of glasses into that of a scientific diagnostician of refractive defects, and as

this change becomes more and more universal among optometrists the layman will be quick to note it, and his response will be both sure and grateful.

C. C. K.

ONE OF THE DANGERS OF FREE VISUAL CLINICS

Dr. C. M. Sageser, optometrist of Rapid City, South Dakota, sends in a newspaper clipping regarding a free visual clinic held in Jones County. The purpose of this clinic was no doubt worthy and, from the tone of the report, the ophthalmologist and layman officials in charge unquestionably felt that much splendid work had been done—however, here is the real danger in this sort of thing. On the first day the refractionist examined the eyes of 82 persons, and on the second day he examined some 78 more, to say nothing of driving from one town to another. Of this number 43 patients were told they needed no glasses, 51 were told they needed glasses and ordered them and 66 were given prescriptions to be filled later.

How anyone, be he an ophthalmologist or an optometrist can refract the eyes of 80 odd patients in the course of one day is beyond all comprehension. As every refractionist knows, at least 30 minutes must be given to each case and in many cases much more time is needed to satisfactorily correct and prescribe for the ocular defects present. A visual survey covering this group might be made, but to attempt to prescribe for visual defects from survey findings (and in this case, this must have been done), certainly stamps the entire visual clinic as being both carelessly conducted and harmful to the patients' best interests to say nothing of setting a very bad precedent.

Visual Clinics, when widely advertised frequently draw large crowds, but it must be remembered that these crowds come because they expect service, and for a single clinician to rush them through, just because they are present is a practice which must be stopped, or clinics of this sort will receive a "black eye" from which they will never recover.

C. C. K.

CO-OPERATION.

"I think it was tripe—or maybe it was pigs' feet.

"Anyway, there were two canners putting it up, and one was a big fellow, and the other a little one. The big fellow had a research laboratory that overcame technical difficulties as they arose, while the other worked largely by rule of thumb. The big fellow put up many times the modest output of the little felow, and had national distribution, where the latter was satisfied with territory comprising three of four states around his plant.

"In canning tripe, black spots would develop soon after the tins were processed and sealed. There was nothing harmful in the spotted meat, but it was unsightly and made people suspicious. This trouble hit both the big canner and the little one about the same time. The big fellow set his chemists at work, and after some months they found a simple way to prevent spotting. The little fellow, too, tried to find out what was wrong, but, lacking the aid of scientific experts, was unsuccessful.

"He heard, however, that his big competitor had discovered how to overcome the difficulty, and this was confirmed by purchasing samples of his product in the open market and cutting them—they came out free from blemish. So he wrote the big canner, frankly told him his trouble, congratulated him upon having found a remedy, and asked if he would tell him how it was done.

"'Why should I?' reflected the big canner, reading the little fellow's letter. 'It cost me money to cure this trouble. It gives my product the advantage in sales and reputation. What cheek! Asking me to give him for nothing this result of my enterprise and money!'

"He forgot the little fellow's letter until the next day, when it again turned up on his desk. And then it struck him in an entirely different way.

"'If I don't show him how to eliminate spots, he'll keep on packing a defective product. Every time a woman opens one of his cans and finds the meat spotted, it will throw suspicion upon all canned tripe. Mine will come under suspicion too. In

other words, unless I show this competitor how to get rid of the spots, his product will be killing my demand.'

"Whereupon he invited the little canner to come to his plant and see just how the thing was done."

The foregoing tale with its obvious moral was taken from among the recent writings of J. H. Collins, a special contributor to **"Printer's Ink,"** who pointed out how the religiously guarded business secret of by-gone years was fast disappearing and how the manufacturing plants of today were doing everything possible to improve the relationship of their inner-trade conditions, thus enabling them to better serve the public.

If it becomes advantageous for the mere business man to go to these ends to better serve his trade—how far more necessary it becomes for all professional men to co-operate in like manner to give the best possible service to their patients.

Every optometrist should constantly be striving to raise the level of his own professional practice and that of his colleagues, and it becomes his duty to assist at any and all times his fellow refractionists in every possible way. By a wholehearted co-operative spirit of this sort optometry would advance in the public estimation, and much good could be accomplished in conserving the nation's eyesight.

REPORTS AND ANNOUNCEMENTS OF SOCIETIES

THE AMERICAN OPTOMETRIC CONVENTION

The convention was opened officially Monday morning, June 15th, by the President, Dr. Thomas H. Martin. The Hon. Huston Quinn, Mayor of Louisville, welcomed the A. O. A. delegates to the city. Dr. Martin responded with an address of acceptance in behalf of the A. O. A. Reports were then rendered by Dr. E. H. Kiekenapp, national secretary; Dr. Rily H. Spittler in charge of legal and legislative affairs; Dr. Ernest Eimer, who reported on the board of boards activities; Dr. A. M. Skeffington reported upon the successful clinical activities carried on during the year.

Dr. Arthur Hoffman, Minneapolis, reported on the work of the department of publicity and public information of which he is chairman. He pointed out the numerous activities carried on by that department and mapped out a plan for broadening these activities for the coming year. The report and recommendations of Dr. Hoffman were well received and the matter was turned over to a special committee for further consideration.

San Francisco was the unanimous choice for the 1926 convention of the A. O. A.

The problem of education received considerable discussion on the floor of the convention. Drs. R. C. Peckham and Ernest Eimer were championing the cause of higher education, advocating a four-year course in optometry schools, while Drs. Pascal and Aronsfeld believed two years were sufficient to prepare for the practice of optometry.

The lecturers at the convention were: Dr. R. M. Peckham of Waterbury, Conn.; Dr. Geo. T. Warren, Washington, D. C.; Prof. Howard Minchin, Columbus, Ohio; Dr. F. P. Barr, Rochester, N. Y.; Dr. E. H. Silver, Washington, D. C.; Dr. Jos. I. Pascal, New York City; Dr. H. L. Raub, Ph.D., and Frank Pirkey, M.D., of Louisville.

Exhibitors at the convention were: American Optical Co., C. G. Aldrich Co., Bausch & Lomb Optical Co., Bay State Optical Co., Harold M. Bennett Co., Chadbourne Co., Cameron Surgical Co., C. V. Lens Co., Eastern Optical Co., Geneva Optical Co., Hamilton Manufacturing Co., Kentucky Optical Co., One Piece Bifocal Lens Co., New Era Optical Co., J. E. Reid Instrument Co., Riggs Optical Co., Shur-On Standard Optical Co., Simpson Walther Lens Co., White Haines Optical Co., Weissfeld Manufacturing Co.

Amongst the resolutions passed were two of major importance, namely: the traveling library resolution, which recommends to the Board of Directors to take steps toward the establishment of a circulating optometric library following the plan of Dr. Fay McFadden; the other resolution called for the creation of an emergency fund. Ten thousand dollars is to be set aside, more to be added from time to time as found practical. This is to be known as the Optometric Foundation.

On Thursday, June 18th, following the report of the resolutions committee, election of officers took place. The following were elected for the coming year: President, Dr. Walter F. Kimball of St. Joseph, Mo.; First Vice President, Leo Mayer of New York City; Second Vice President, Rily H. Spittler of Eaton, Ohio; Treasurer, Chas. M. Jenkins of Richmond, Indiana.

The new Board of Trustees is made up of Drs. Thomas Martin, Pittsburgh, Pa.; Fred Stengel, Marion, Ohio; E. O. Sterzer, Dayton, Ohio; E. H. Kiekenapp, Faribault, Minnesota, and Thos. H. Mowe, Louisville, Kentucky.

NORTH DAKOTA CONVENTION

The North Dakota Optometric Association will hold their next annual meeting at Mandan on the 3rd and 4th of August, headquarters at the Lewis and Clark Hotel.

A good program is assured by the arranegments committee consisting of Drs. H. Kornmesser, Jamestown; A. S. Anderson, Fessenden; C. G. Conyne, Mandan; R. E. Bonham, Bismarck; and D. D. Sullivan,

Fargo. An optometric lecturer of national reputation will give an instructive talk on certain phases of refraction technic. There will be a round table discussion led by Dr. Sullivan of Fargo on ways and means of combating spectacle peddlers, mail order spectacles, violators of the optometry law, etc. Everyone is invited to take part in this discussion. There will also be a question box on matters pertaining to everyday office practice.

No effort has been spared to make this convention entertaining as well as educational. There will be special entertainment for the ladies and excursion trips for everyone, including visits to the state capital, state penitentiary, and other points of scenic and historic interest in and around Mandan. There will also be a golf tournament on one of the best courses in the state. All optometrists who are golf addicts are urged to bring their clubs and participate in this event, whether or not they ever shot below 100. And, of course, there will be the usual banquet on the closing day of the session.

Many optometrists are going to bring their families, attend the convention, and afterward spend several weeks motoring and camping in the North Dakota Bad Lands. North Dakotans who have never visited this section do not know that it is truly one of the scenic spots of the United States and is under consideration by the federal government for the establishment of a national park similar to the Yellowstone and Yosemite.

We also extend a cordial invitation to optometrists from neighboring states.

A. S. ANDERSON, Opt. D.,
Secretary.

Dr. A. S. Anderson visited Dr. Kornmesser at his home in Jamestown the second week in June to plan for the coming convention. A complete program will be published in the August issue of the Journal.

BULLETIN OF THE OKLAHOMA ASSOCIATION

E. B. Alexander, Opt. D.

We have just completed the organization of fifty-one county optometric societies.

These societies will carry on educational, publicity, and law enforcement work, under the direction of our State Association.

A chairman has been appointed for each society, and we will let them work out the organization best suited for their individual county.

Another convention has come and gone, each convention seems to be more successful than the preceding one, and it should be. There is no question but what Optometry as a profession is progressing at a great rate, and unless you attend these meetings you lose much. About 80% of the membership of the Association attended this last convention, probably a record for any similar state organization.

At the end of this bulletin you will find the revised Code of Ethics adopted by the State Board of Examiners in Optometry. This code of ethics is LAW and is as enforceable as any other section of the Optometry law. A copy is being mailed each registered optometrist in the state, so that no one can claim ignorance of its provisions. Reports of violations of this Code of Ethics will be investigated, and if found to be true, charges will be filed with the State Board. If found guilty by the Board, the license of the guilty party may be revoked permanently. No favoritism will be shown. Members of this association will be prosecuted as quickly as a non-member. Within a few days you will receive a copy of the Association's Code of Ethics suitable for framing. Frame it and hang it on your office wall. Let your patients know where you stand. The public prefers to deal with those who in their profession are ethical and are striving to do as they would be done by, because such an establishment always gives better service. Codes of Ethics are not written and adopted for the purpose of limiting or handicapping anyone, but for the purpose of guiding you in your practice so that you will be more successful. A strict adherence to a proper code of ethics is a mighty good business proposition.

Code of Ethics Adopted by the Oklahoma State Board of Examiners in Optometry, April 19th, 1923, and Revised April 21st, 1925

Every Optometrist practicing in the State of Oklahoma should conduct his practice in a manner to reflect credit on his profession, honor and profit to himself, and give his best service to his patients.

It shall be considered unprofessional and unethical to—

(a) Conduct your practice in a manner likely to deceive or defraud the public; or,

(b) Obtain any fee by fraud or misrepresentation, or;

(c) Employ either directly or indirectly any person or persons commonly known as "cappers" or "steerers" to obtain business, or;

(d) Solicit, or employ any person or persons to solicit patronage from house to house, or in any public place, or;

(e) Employ an unregistered person or persons to perform any act prohibited by the law governing optometry in Oklahoma, or;

(f) Advertise prices, or untruthful and impossible claims regarding treatments, cures or values, or;

(g) Do any material act which would disqualify an applicant for examination before this board, or;

(h) Violate any provision or provisions of the Optometry laws of Oklahoma, or;

(i) Violate any published rule of the Oklahoma State Board of Examiners in Optometry, or;

(j) Violate any section which may be regularly added to this code.

IOWA ASSOCIATION CONVENTION

Des Moines, Iowa, June 9-10
Dr. Geo. C. Griffith Presiding

Dr. Griffith in his opening address pointed out the advancement made by the profession during the past year and congratulated those present for having much to do with this improvement in Iowa. He referred to the new optometry law and to the code of ethics now in force as two of the highlights of the progress of the year.

Dr. R. F. Nuckolls, of Grinnell, next presented a short financial report which showed a pleasing bank balance.

Dr. E. W. Martin, of Carroll, Chairman of the Department of Publicity, followed Dr. Nuckolls and outlined how his department had co-operated with the A. O. A.'s department in sending out booklets, etc., during the past year. Dr. Martin spoke at length advocating the A. O. A. national advertising campaign.

Dr. D. A. Kinney, of Charles City, followed Dr. Martin. Dr. Kinney as Chairman of the Department of Organization reviewed the work of the past year in securing new members for the association, and stated that he was very pleased to find that Iowa stood well up in the ranks of State Societies when it came to percentage membership. He stressed the need for professionalism and pointed out that education and confidence were the most needed requisites for success.

Dr. G. L. Goodale, of Lenox, the Secretary, next read his report. He started out, explaining for the benefit of the new members present the exact type of organization now in force and the kind of reports to be submitted, etc., and in a general way reviewed the activities of the state association. He also told of making a state survey to determine exactly how optometry was being practiced in Iowa. In making this survey he found that there were 555 optometrists now engaged in refractive work in the state and that nearly one-half of them belonged to the state society.

The educational portion of the meeting now started. Dr. P. S. Helnic giving the first talk, his subject being "Radiant Energy." He was followed by Dr. Kunerth, who presented a paper on the effects of ultra-violet light on body tissues.

Dr. J. G. McMasters, Dr. J. M. R. Hanson and Dr. Nuckolls next presented the legislative report, in which was reviewed the work of the past year, largely taken up with the passage of the new optometry act, an act which they believe to be one of the best in the country.

Following this committee's report, Miss B. Short, Superintendent of the Des Moines Public School Nurses, gave a demonstration of the school examination. Miss Short was followed by Miss E. Countryman, who spoke on the State's activities for the conservation of health.

Dr. C. C. Jones next spoke on "New Findings in Ocular Pathology," which was splendidly received.

At 6:00 P. M. the annual banquet was held at the Des Moines Chamber of Commerce.

The following morning Dr. T. G. Atkinson, of Chicago, spoke on the "Forms of Ocular Pathology That the Optometrist Must Be Familiar With." This splendid lecture was followed by the business session, at which the following men were elected:

Drs. P. H. Johnson, Davenport, President; D. A. Kinney, Charles City, First Vice President; E. W. Martin, Carroll, Second Vice President; F. E. Robinson, Ames, Third Vice President; R. F. Nuckolls, Grinnell, Fourth Vice President; and Geo. L. Goodale, Lenox, Secretary.

The usual resolutions were passed, after which clinics were arranged which lasted until 6:00 P. M.

THE TENNESSEE CONVENTION
Memphis, May 18-19

The main feature of the convention was a clinic conducted by Dr. A. M. Skeffington of Kearney, Nebr., and every optometrist who attended agrees that there is nothing else which can be compared with post-graduate clinics for educating, not only the practitioners, but also the public. The attending optometrists see patients examined and are told of conditions found, reasons for results obtained and prescription given. The high class of patients who seek clinical aid demonstrates that the educated people are beginning to realize that the optometrists are specialists in the conservation of vision.

Dr. Skeffington's spare time was taken up by speaking engagements before two high schools, a civic club, and a talk over the radio from station WMC. His public talks dealt with conservation of vision and the difference between visual efficiency and sight.

Dr. Thelma White Bass presided at the convention. The speakers beside Dr. Skeffington were Mr. E. A. Forshey of the American Optical Co. and Mr. J. H. Mitchell of the General Optical Co.

The banquet was at the Claridge Hotel, Tuesday, at 6:30 P. M., about 75 attended.

The officers for the new term are as follows: President, Dr. Thelma White Bass, Nashville; First Vice President, Dr. Vance C. Roy, Memphis; Second Vice President, Dr. R. S. Davis, Knoxville; Third Vice President, Dr. O. B. Radebaugh, Nashville; Fourth Vice President, Dr. J. E. Davies, Chattanooga; Secretary-Treasurer, Dr. W. Fred Gates, Chattanooga.

The next meeting place will be Chattanooga, the Dynamo of Dixie, the scenic center of the South.

THE FLORIDA CONVENTION

Fifty-six optometrists attended the twenty-first annual convention of the Florida Optometric Association, held in Jacksonville on May 27th and 28th. Former Secretary Weihe writes that it was the best state association convention held to date and that Dr. A. M. Skeffington and Dr. E. A. Forshey performed their duties on the educational program in a splendid manner. During a short business session the following optometrists were elected to serve the society for the coming year: Dr. D. P. Galvin, President; Dr. J. O. DuBose, Vice President; Dr. E. M. Ingram, Secretary-Treasurer. In addition to the above named, the following will serve on the executive committee: Drs. K. K. EyChaner, H. O. Bumpous and J. M. Morqus.

Vero Beach has been selected for the meeting place in 1926.

THE KENTUCKY CONVENTION

The Kentucky convention was held June 18th at the Brown Hotel at Louisville during the A. O. A. convention week. Dr. J. J. Byrne of Danville was elected President for the coming year, Dr. H. K. Fulkerson of Sommerset as Vice President and R. O. Warren of Lexington, Secretary-Treasurer.

The State Board of Examiners was censored for their inactivity and a resolution was passed urging the state board to take immediate steps to clean up the state of the traveling fakers who are so numerous of late.

The Stoco Short Skullfit and the Stanrite Frame

THE ADDITION of Stoco Short Skullfit temples to the Stanrite frame, on which they are supplied exclusively, gives this popular and practical frame still another angle of appeal.

These temples conform ideally to those features of design and construction which have made the Stanrite the country's leading frame, enhancing the appeal of the frame, especially to women, by the convenience and wearing ease of this style of temple.

Standardize on Standard Optical Products

We are making these temples in 4¾", 5" and 5¼" lengths and are, of course, putting into their cores the good Stoco metal which can be so readily adjusted, yet which holds so tenaciously.

Shur-on Standard Optical Company,
INCORPORATED

Geneva, N. Y., U. S. A.